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MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-010259

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 71

Primary Registration District No. 3010

Registrar's No. 22

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAR 16 1962

1. PLACE OF DEATH

a. COUNTY Clay

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN Excelsior SpringsLength of stay in 1b
yearsc. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION 206 West ExcelsiorInside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY Clay

c. CITY OR TOWN Excelsior Springs

Inside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)
206 West Excelsior St.Reside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)First Middle Last
Earl W Smith4. DATE OF DEATH Month Day Year
March 7, 1962

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☐ Never Married ☒Widowed ☐ Divorced ☐

8. DATE OF BIRTH

7/26/1893

9. AGE (last birthday)

68

IF UNDER 1 YEAR IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired city assessor10b. KIND OF BUSINESS OR INDUSTRY
City11. BIRTHPLACE (City and state or country)
Lake City, Iowa12. CITIZEN OF WHAT COUNTRY
U.S.A

13a. FATHER'S NAME

Jacob B. Smith

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

206 Ridge Ave
Harley N. Smith, Crystal Lake, Illinois15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of serv)
Yes W.W.I

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Unknown - Probable Coronary

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Occlusion

DUE TO (c)

Chronic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from _____, to _____ and last saw her alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL HOME, ETC.

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Excelsior Springs, Missouri

3-10-62

Caroline Hutchings

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

MAR 16 1962

JUL 3 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Ralph Van Ledingham

Licensed Embalmer No. *4009*

P. O. Address *Elkton Springs, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.